Reset Form Print Form

New Hampshire Medicaid Fee-for-Service (FFS) Program
Prior Authorization/Non-Preferred Drug Approval Form

GLP-1 Agonists

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH: – –

GENDER: ☐ Male ☐ Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER: – –

FAX NUMBER: – –

SECTION III: CLINICAL HISTORY

1. Does the patient have a diagnosis of a type 2 diabetes mellitus? ☐ Yes ☐ No

   If no, provide diagnosis: _____

2. Will the therapy be used as an adjunct to diet and exercise? ☐ Yes ☐ No

3. Has the patient had prior use of an oral anti-diabetic drug? ☐ Yes ☐ No

   If yes, provide treatment and dates: _____

   If no, provide contraindication or adverse effect: _____

4. Are there any other comments, diagnoses, or medication trials that would be important to this review? ☐ Yes ☐ No

   Provide details: _____

(Form continued on next page.)

New Hampshire AIDS Drug Assistance Program
Prior Authorization/Non-Preferred Drug Approval Form
GLP-1 Agonists

PATIENT LAST NAME:

PATIENT FIRST NAME:

SECTION IV: NON-PREFERRED DRUG APPROVAL CRITERIA

Chapter 188 of the Laws of 2004 requires that Medicaid only cover non-preferred drugs upon a finding of medical necessity by the prescribing physician. Chapter 188 requires that you base your determination of medical necessity on the following criteria.

☐ Allergic reaction. **Describe reaction:**

_____

☐ Drug-to-drug interaction. **Describe reaction:**

_____

☐ Previous episode of an unacceptable side effect or therapeutic failure. **Provide clinical information:**

_____

☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug. **Provide clinical information:**

_____

☐ Age specific indications. **Provide patient age and explain:**

_____

☐ Unique clinical indication supported by FDA approval or peer reviewed literature. **Explain and provide a reference:**

_____

☐ Unacceptable clinical risk associated with therapeutic change. **Please explain:**

_____

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

Phone: 1-800-424-7901
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